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ABSTRACT

Evaluated were 430 new juvenile and adult admissions to a state residential facility for the mentally retarded (MR). The study was part of Project CAMIO (Correctional Administration and the Mentally Incompetent Offender), a Texas effort to determine the incidence of criminal incarceration of the MR and to identify laws, procedures, and practices which affect the prosecution and imprisonment of the MR offender. Investigated were the incidence of Ss' prior involvement with the criminal justice system and the incidence of anti-social behaviors while at the institution. Most common antisocial behaviors identified were tantrums (one of every four individuals) and assaultive behaviors (one of every four juvenile males). Only 10% of the Ss had had any prior contact with the criminal justice system. Results suggested that the high incidence of anti-social behaviors among residents reguires the development of specialized programs within institutions for the retarded and that MR delinquents are more likely to be committed to state correctional institutions than to state facilities for the MR. (DB)

The Delinquent in a State Residential Facility for the Mentally Retarded

PROJECT CAMIO
Volume 6

PROJECT CAMIO

CORRECTIONAL ADMINISTRATION AND THE MENTALLY INCOMPETENT OFFENDER

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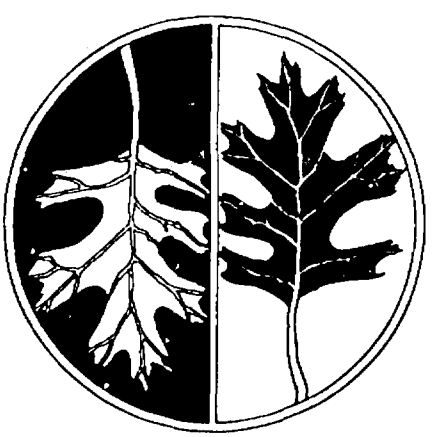
Graphic Design by Beth Bartosh

The Delinquent in a State Residential Facility for the Mentally Retarded



PROJECT CAMIO
Volume 6

ACKNOWLEDGEMENTS

The present study involved an investigation to determine the incidence of delinquency and a comparison of criminal and social history backgrounds among mentally retarded residents within state facilities for the retarded. The authors appreciate the cooperation of the superintendents of the various state schools who greatly facilitated the gathering of this information. In particular, the authors wish to express their appreciation to the caseworkers in the various state schools who completed detailed behavioral rating forms to determine the extent of anti-social or delinquent behavior among the subjects included in the sample.

The coordination of this effort was primarily directed by two research assistants, Messrs. William E. Sharp and George Wells, whose patient efforts in gathering the data greatly facilitated this investigation.

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1.0 INTRODUCTION

On September 1, 1965 the Texas Department of Mental Health and Mental Retardation succeeded the State Board for Hospitals and Special Schools and the Division of Mental Health of the Department of Health as the agency responsible for the care and treatment of the mentally ill and mentally retarded of Texas. House Bill 3, as enacted by the 59th Legislature, provided for the conservation and restoration of mental health among the people of Texas, and toward this end provided for the effective administration and coordination of mental health services at the state and local levels.[1] This bill was also intended to provide, coordinate, develop, and improve services for the mentally retarded of the state to the end that they would be afforded the opportunity to develop to the fullest practicable extent and to live useful and productive lives.

At the time of this study, the Texas Department of Mental Health and Mental Retardation supervised nine mental health hospitals, two mental health out-patient clinics, the Texas Research Institute of Mental Sciences, two state centers for human development, a rehabilitation and recreation center, and ten state schools for the mentally retarded.[2] The Department was also responsible for making grants-in-aid to community mental health/mental retardation centers governed by local boards of trustees. Services for rural areas were provided through outreach programs, extended by state mental hospitals and state schools for the mentally disturbed.

During the period of September 1970 through August 1971, the total residential population of the ten state facilities for the mentally retarded numbered 12,876. In addition, human development centers at Amarillo and Beaumont served approximately 350 mentally retarded children and adults on an out-patient basis. Also, during this period, state residential facilities for the mentally retarded admitted 835 new admissions, with particular emphasis on serving the more severely retarded, i.e., those individuals with IQs below about 50.[3]

Since its creation in 1965, the Department of Mental Health and Mental Retardation has realized that some mentally retarded individuals manifest anti-social behaviors which disrupt the normal routine of residential facilities. The literature has identified these individuals as defective delinquents or predelinquent retardates. Regardless of definition, they constitute a peculiar administrative problem for those charged with the responsibility of the care of the mentally retarded. Though they are relatively few in number, their aggressive and acting-out behavior is disruptive to normal routine, and in some cases, can endanger the property and persons of other residents and staff.

Whether there has been an increase of such anti-social mentally retarded persons in recent years, and whether this is correlated with the rise in youth crime in the general population, is not known. Nevertheless, the problem emanates from the fact that

there is a diversity of opinion as to the meaning of the term defective delinquent. Theorists in some quarters would define the defective delinquent as a mentally retarded individual who manifests behavior which is disruptive to the administration of residential facilities. For others, the term implies an adjudicated mentally retarded person who is known to have committed criminal acts. Though there is some disagreement as to the definition of the term defective delinquent, there is little doubt that this individual presents peculiar administrative problems in residential facilities.

In searching for administrative strategies for the care and treatment of the defective delinquent, two alternative procedures come to light. The first involves referring acting-out retarded individuals to an appropriate court for adjudication and commitment to facilities designed to care for the delinquent or adult criminal. Certainly, the advantage of this approach is the removal of the individual from a residential facility for the retarded and placement in a facility where custody and security are the prime objectives. However, this alternative is not customarily employed by specialists in the field of mental retardation. Since there is serious question as to the mental competency and criminal culpability of such individuals, referral to the juvenile or adult criminal justice system and ultimate commitment to a state training school or prison does not solve the problem with respect to the retarded individual, but simply moves the problem from one agency to another.

A second administrative alternative involves the construction and operation of specialized security units for defective delinquents. Such a solution involves a compromise between the custodial advantages of a state reformatory or correctional facility, and the treatment milieu of a residential facility for the mentally retarded. As straightforward as this solution may appear, it does present some legal difficulties worth examination. This alternative suggests the placement of the defective delinquent in a security environment and may legally constitute incarceration without adjudication or due process. While residential facilities are responsible to receive and treat individuals committed by action of a civil court, it is unclear whether they have the authority to hold a resident in custody because of anti-social behavior which he manifests within a residential facility. This is not to say that custody is not beneficial both to the individual and the institution, but the question remains as to what procedures must be employed so as to assure the constitutional guarantees of due process.

The purpose of this study was to explore the incidence of anti-social and criminal behavior of residents of state residential facilities for the mentally retarded in Texas. The importance of the study rests upon the fact that adequate residential and treatment alternatives cannot be realistically designed without adequate knowledge as to the incidence and severity of the problem. It is the objective of this study, then, to develop a set of criteria for defining anti-social behavior and delinquency among

residents of residential institutions for the mentally retarded, determine the incidence of individuals who fit these criteria, and to develop alternative strategies for their residential security and treatment.

The remainder of this report is divided into four parts including a description of the legal basis and administrative organization of the Texas Department of Mental Health and Mental Retardation, a description of the methodology employed in the design of the study, a discussion of the results, and a summary of conclusions and recommendations.

Footnotes

[1]Vernon's Texas Civil Statutes, Article 5547-2.01.

[2]Ibid.

[3]Texas Department of Mental Health and Mental Retardation, Annual Report: 1971, Austin, Texas, 1971.

2.0 THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Although the focus of this study involved the identification of delinquency and anti-social behavior among residents of state residential facilities for the mentally retarded, it seems appropriate to discuss the administrative structure of the Texas Department of Mental Health and Mental Retardation prior to addressing methodology and results. The following section is divided into two parts; the first provides a discussion of the Mental Health and Mental Retardation Act which created the Department, the second section provides a description of the organizational structure of the Department and procedures for admission to a state residential facility for the mentally retarded.

2.1 Legal Basis

Prior to 1965, the responsibility for the care of the mentally retarded and mentally ill was vested in several state agencies including the Board of Texas State Hospitals and Special Schools and the Division of Mental Health of the State Department of Health.[1] It was recognized that having the responsibility for the care of the mentally ill and mentally retarded diversified in several state agencies did not provide the efficiency and, in some cases, the quality of care that could be provided through the centralization of services.

In 1965, the 59th Legislature enacted legislation creating the Texas Department of Mental Health and Mental Retardation.[2] This

Act centralized all state level services for the mentally ill and the mentally retarded under the Texas Department of Mental Health and Mental Retardation. The statute created the Texas Board of Mental Health and Mental Retardation composed of nine members appointed by the Governor with the advice and consent of the Senate.[3] Each of these members serves a six year term with no compensation other than per diem expenses accrued during the actual performance of their duties.

The executive officer of the Department of Mental Health and Mental Retardation is known as the Commissioner.[4] Whereas the Board formulates the broad policies of the Department, the Commissioner's responsibility involves the translation of these policies into the daily administration of the agency. The Department is divided into various divisions according to function, but for purposes of direct service delivery there are three prominent entities; one dedicated to mental health, one to mental retardation, and one to comprehensive community mental health/mental retardation services. Each of the three divisions is administered by a Deputy Commissioner who reports directly to the Commissioner (c.f. Figure 1).

The Department is authorized to appoint various medical advisory committees and such other committees as are deemed appropriate to assist in the effective administration of services.[5] Aside from authorization to maintain residential facilities for the mentally retarded, the Department is also authorized to provide other services for the convenience of mentally retarded

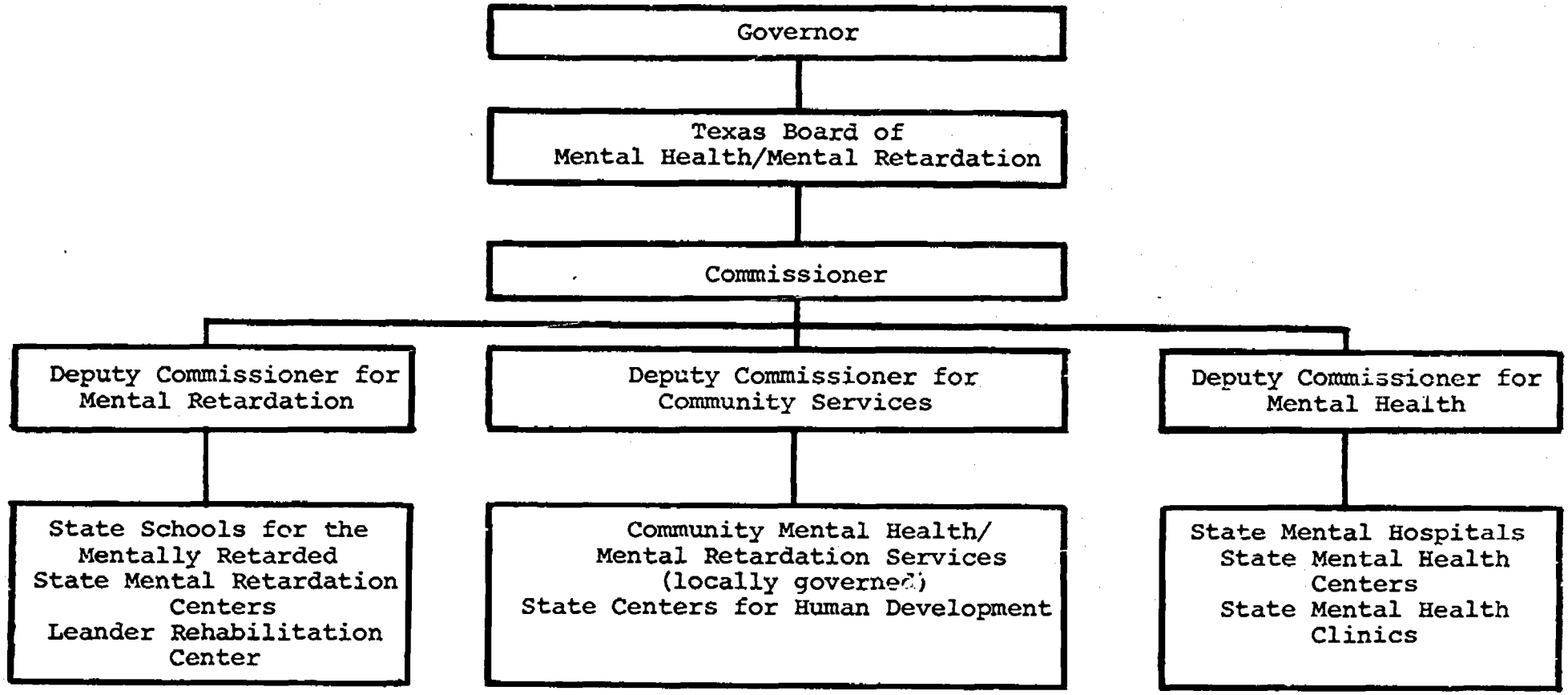

Figure 1 ADMINISTRATIVE FLOW CHART

OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

persons within various communities of the State. This service is designed to augment special education classes usually conducted in the public school system, as well as fill service voids which exist at the community level.

2.2 Administration

As mentioned previously, for direct service delivery, the Department is divided into three divisions; a division of community services, a division of mental health, and a division of mental retardation. The division of mental retardation is administered by a Deputy Commissioner who is responsible for the administration of the various schools and centers for the mentally retarded.[6] At the time of this study, the Department operated ten state schools for the mentally retarded (c.f. Figure 2). Each of the state schools, in turn, administers a variety of outreach programs and services to assist retarded individuals within the community.

Article 3871b, Texas Civil Statutes, defines mental retardation as follows:

> A mentally retarded person means any person other than a mentally disordered person, whose mental deficit requires him to have special training, education, supervision, treatment, care or control in his home or community or in a state school for the mentally retarded.

For purposes of administration, this definition of retardation has been translated by the Department to mean any person who has sub-average general intelligence functioning which originates

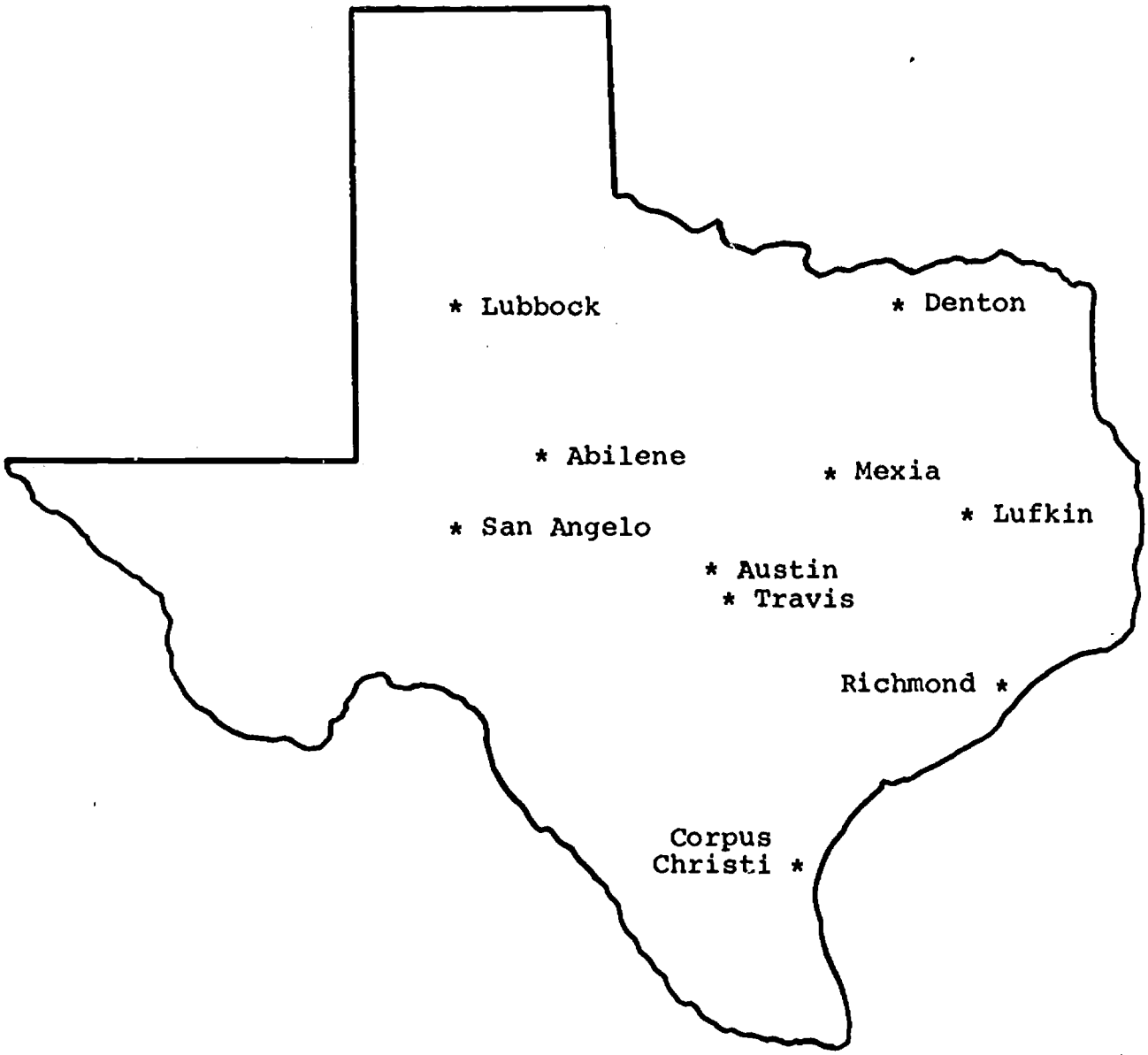

Figure 2 DISTRIBUTION OF STATE SCHOOLS FOR THE RETARDED

during the developmental period and is associated with impairment in adaptive behavior.

Two procedures for admission to a state school are employed by the Department. These include voluntary admission and judicial commitment. In order to make application for a voluntary admission to a state school, both written application by the parents or legal guardian of the individual and an examination at an approved diagnostic and evaluation center are required. In the case of a judicial commitment, the county court of the county wherein the person resides has jurisdiction over all judicial commitment procedures. In order to file for a judicial commitment, an application must be filed with the county clerk. Once this filing has occured the county judge must set a date for a hearing on the application. At the hearing a determination is made regarding whether the person concerned is mentally retarded. If a finding of retardation results and the person is deemed in need of supervision, the county judge then issues an order to have the person admitted to the Texas Department of Mental Health and Mental Retardation (c.f. Figure 3).

Regardless of whether the basis for admission is voluntary or judicial, the applicant must have been a resident of the state of Texas for at least one year prior to making application. In the case of a minor, his parents must meet the residency requirements. Military personnel and their dependents, though only temporially based in a state, must meet the same residency requirements.

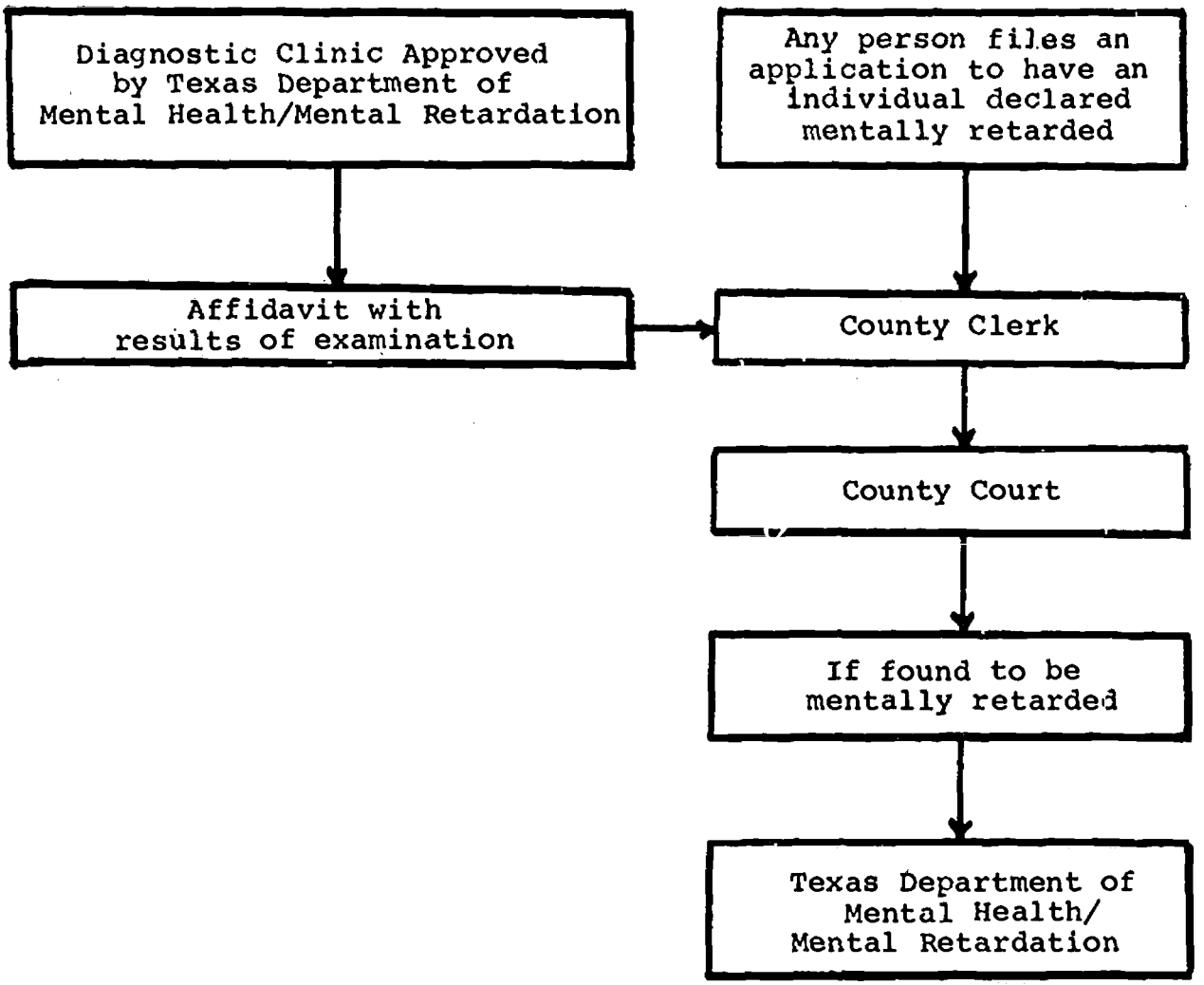

Figure 3 INVOLUTARY COMMITMENT PROCEDURES UNDER THE MENTALLY RETARDED PERSON'S ACT

Once application for admission has been made, the state school or diagnostic and evaluation center assembles a case file which includes information in the following areas:

- Developmental History
- Medical History
- Family History
- Financial Statement
- Social History
- Psychological Evaluation
- Recent Photograph
- Immunization Record
- Birth Certificate
- Court Commitment Papers (if applicable)
- Evidence of Custody: in cases where children come from divided homes

The superintendent of a state school may admit individuals to a facility for purposes of observation and evaluation prior to a final decision concerning eligibility. Applicants for admission must be certified by a local mental health/mental retardation center if one is available, in order to screen individuals who do not require residential care and could be better served in the community.

When the application is completed, the superintendent of the state school is authorized to determine the eligibility of persons for placement in the school. Criteria for eligibility include whether the individual is mentally retarded as defined by law,

whether community-based services could be utilized as an alternative to residential care, and whether the best interest of the applicant would be served by admission to a state school. After eligibility is determined, the applicant is rated on a priority scale for admission. Criteria used for assigning priority include availability of alternative community-based services, the extent of mental and physical disability, and the date of placement on the waiting list for admission.

Applicants on the waiting list are placed in residential facilities according to the geographical location of residency. When vacancies exist, applicants are placed in facilities which serve their particular community. In the case where no vacancy exists in the institution closest to the applicant's residence, and when one exists at another school, the applicant has the option to be admitted to the unit outside his area of residency.

The waiting period for admission to state residential institutions ranges from six months to three years, depending upon geographic area, urgency of need, and availability of openings. Individuals from high density population centers such as Houston, Dallas, and San Antonio frequently face longer waiting periods than persons in other areas due to the greater press on available facilities in these urban centers. Due to the escalation of residential costs and budget limitations, the trend in recent years is for the state facilities to admit only those

persons whose disabilities exceed available community resources and services. In years past, the Department admitted less profoundly retarded individuals for short term training and education. However, the Department now relies on community resources to provide this function and at the time of this study were admitting only those persons whose retardation would prohibit them from benefiting from community treatment programs, if available.

Since the primary purpose of this study was to understand the incidence of delinquency and anti-social behavior among mentally retarded individuals within residential facilities, it would seem appropriate to discuss the resocialization unit developed at the Mexia State School. During the last decade the Department became increasingly aware of the difficulties which accrue in the residential care of the acting-out mentally retarded resident. Such individuals, on occasion, represented a threat to other residents, and sometimes to the staff. In recognizing the need for specialized facilities and programs for these individuals, in 1966 the Governor's Interagency Committee on Mental Retardation Planning recommended that provision be made for specialized facilities for the handling of delinquent retardates or retardates convicted of crimes.

In response to this recommendation, the Department constructed a twenty-four bed resocialization unit at the Mexia State School for the intractable male defective delinquent. Once this facility was opened, it became immediately apparent that twenty-four

beds would not adequately house the number of referrals from other state schools involving individuals with acting-out problems. As a result, other units were developed at Mexia and used for less severely problematic retardates with only the most severe cases assigned to the resocialization unit.

The number of interdepartmental referrals of defective delinquents increased rapidly over the next few years. To meet this increasing need the Mexia State School made application in 1969 to the Division of Mental Retardation of the U.S. Department of Health, Education and Welfare for a demonstration project to develop programs for the defective delinquent. This program involved the assembly of a team of specialists whose sole responsibility involved development and implementation of a treatment program directed at the needs of approximately 100 acting-out male retardates within the Mexia State School. The core of this treatment program involved behavior modification techniques and resocialization of the residents, the goal being to modify their anti-social behavior so as to be more amenable to social and vocational training prerequisites to total rehabilitation.

The program was designed to work in cooperation with the Department of Inter-Service Training at the facility so as to utilize the assistance of trained para-professionals in the various therapeutic programs. This approach was utilized to decrease the need for employing a disproportionately large number of professional staff.

Since one of the difficulties in working with the defective delinquent is determining which individuals fit this classification, an effort was made to conduct a detailed study of the subjects used in the demonstration project so that model criteria could be developed for defining the defective delinquent. Extensive research was conducted in a variety of areas including examination of the etiology of anti-social behavior, the degree of cognitive deficit, personality structure, type of delinquent behavior manifested, educational/vocational potential, and emotional status. In addition, longitudinal case studies were initiated to follow individuals treated in this program to determine the relative merits of the approach. Reports pertaining to the Mexia State School project are available from the Superintendent.

Footnotes

[1]Vernon's Texas Civil Statutes, Article 5547-2.01.

[2]Ibid.

[3]Ibid., Sec. 2.02.

[4]Ibid., Sec. 2.07.

[5]Ibid., Sec. 2.10.

[6]Ibid., Sec. 2.08.

3.0 METHODOLOGY

The purpose of this study was to identify the incidence of delinquency and anti-social behavior among residents of the state schools for the retarded. This section summarizes the procedures used in the design and implementation of the study. For organizational purposes, this section is divided into two parts; the first presenting a resume of the sampling procedure utilized, and the second discussing the type of information which was gathered on the sample.

3.1 Sampling Procedures

It was decided in the initial planning phase of this study that only recent admissions to the state schools for the mentally retarded would be included in the sample. The rationale behind investigating only new admissions was that it would provide a more contemporary appraisal of the incidence of delinquency than could be gained by studying the entire residential population. Sampling from the population of residents of the state school would not give an accurate picture of the incidence of delinquent behavior due to the possibility that the number of delinquents found would be biased to the extent that a differential discharge rate would exist between delinquent and non-delinquents. This differential could increase the incidence of delinquent residents within the state schools should they be found to be less amenable to treatment and subsequent discharge.

Based upon this consideration the decision was made to sample all individuals admitted to residential facilities for the retarded during fiscal year 1970, covering admissions between September 1, 1969 and August 31, 1970. A computer tape obtained from the Department of Mental Health and Mental Retardation indicated that there were 1981 admissions during this period.

Under Texas law, an individual must be 10 years of age or older to be adjudicated for delinquent acts.[1] Therefore, it was decided to exclude from the study all new admissions during 1970 who were less than 10 years of age. Similarly, retarded individuals who were so severely physically handicapped or otherwise non-ambulatory as to preclude delinquent behavior were also excluded from the sample. Similarly excluded were individuals with IQs of less than 35 who were considered to be so profoundly retarded that they would not be taken before a juvenile court regardless of the degree of their delinquent behavior.

Having identified these exclusionary parameters, the original sample of 1981 new admissions was screened to exclude anyone who had one or more of these characteristics. The results of this screening yielded a final sample of 430 subjects (21.70%), which included 240 males and 190 females. Using the criterion of 21 years of age as the differential between juveniles and adults, the final sample contained 362 juveniles and 68 adults. The sampling procedures utilized and the constituency of the final sample derived is outlined in Figure 4 on the following page.

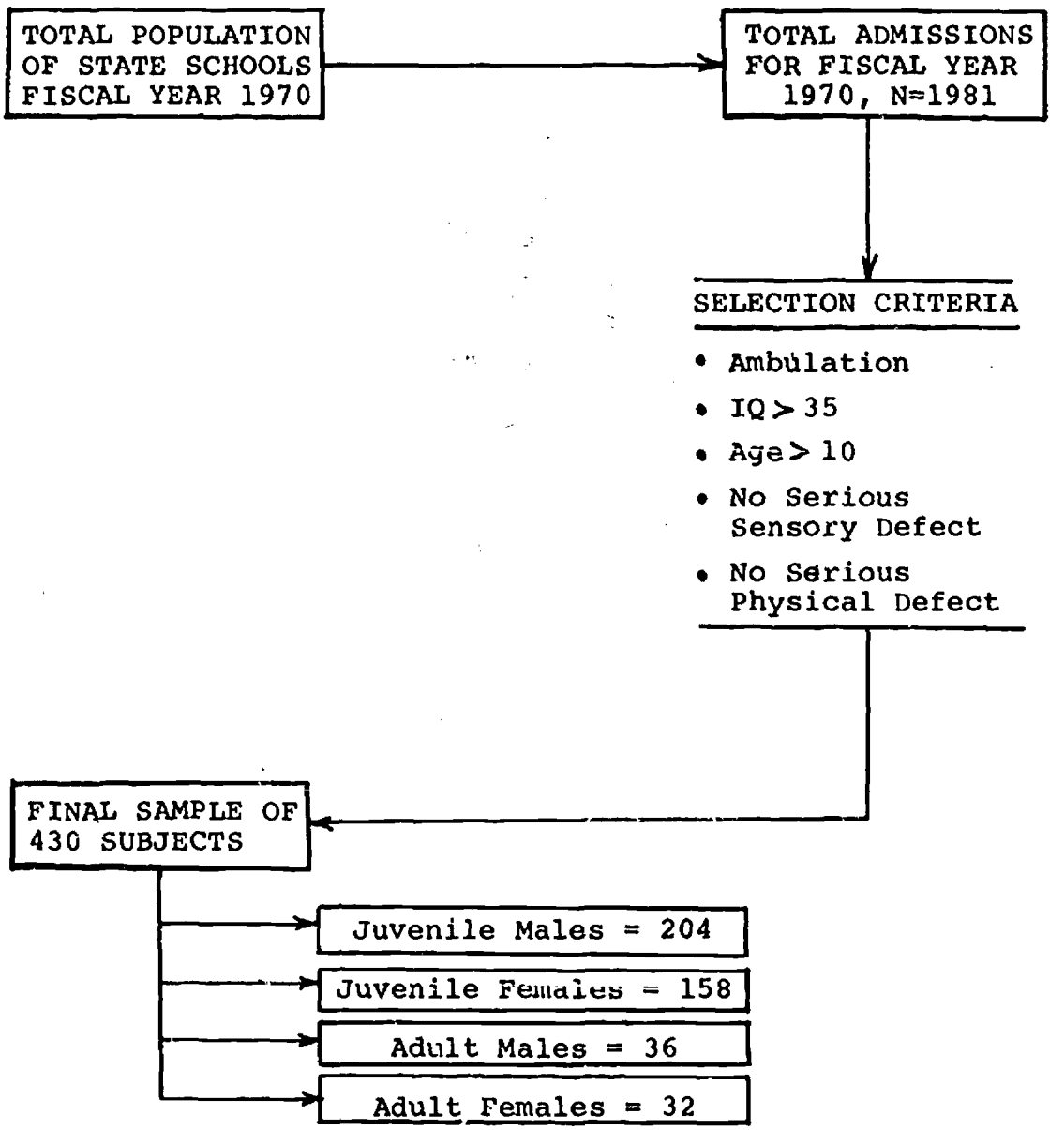

Figure 4 SAMPLING PROCEDURE

It should be mentioned that the conclusions derived from this study can only be generalized to that portion of new admissions that could conceivably fall within the jurisdiction of the juvenile court. Individuals under 10 years of age, the profoundly mentally retarded and physically handicapped, though capable of committing delinquent acts and manifesting anti-social behavior, would not be individuals who in all likelihood would be taken before the juvenile court for formal adjudication and, therefore, were excluded from the study sample. Therefore, the incidence of delinquent histories and anti-social behaviors found in this study is proportionately higher than would be found in a study of all admissions to a state school and this limitation should be kept in mind in interpreting the data.

3.2 Data Gathering Procedures

Based upon conversations with representatives of the Department of Mental Health and Mental Retardation, it was hypothesized that very few residents of the state schools had been formally adjudicated for criminal acts either as juveniles or adults prior to admission to the state school. Yet, these same residents were capable of committing certain acts while in a state school which if committed in the community could well involve their arrest and adjudication. The commission of such acts, however, by residents of a state school are not normally brought to the attention of the law enforcement community and, therefore, the incidence of formal adjudications would be rare. Therefore, the identification of delinquent and anti-social behavior is

made somewhat difficult since it is a matter of observational judgement as opposed to judicial litigation.

Because of these considerations, the researchers developed two different techniques for the definition of delinquency. The first involves the identification of various legal definitions which could characterize an individual's involvement in either the juvenile or adult criminal justice system. These variables involve such things as number of arrests, adjudications, probations, and commitments to juvenile or adult correctional institutions, etc.

The second procedure devised for the identification of delinquent behavior was the development of a list of anti-social and delinquent behaviors which were known to be committed by residents of state residential facilities. These included both acts for which a person could be criminally prosecuted as well as other anti-social behaviors for which juveniles could be adjudicated under the state definition of uncorrigibility or being ungovernable.[2] A listing of those variables included in these definitions of anti-social behavior and delinquency are outlined in Figures 5 and 6 on the following pages.[3]

In addition to gathering information about the subjects prior delinquency record and anti-social behavior, information was also gathered as to the subjects demographic background, family and social history, as well as information regarding their mental retardation, physical impairments, and physical handicaps. A

1. Ingestion - Inedible Objects
2. Putting Objects in Nose/Ears
3. Enuresis
4. Regurgitory Behavior
5. Undressing Publicly
6. Unresponsive/Withdrawal
7. Smearing Feces
8. Running Away
9. Lying
10. Destroying Own Clothing
11. Sexually Aggressive
12. Stealing
13. Homosexual Acts
14. Heterosexual Acts
15. Noisy Behavior
16. Masturbation
17. Head Banging
18. Biting Self
19. Hyperactive
20. Screaming
21. Assault - Employees
22. Assault - Patients
23. Breaking Windows
24. Destroying Property
25. Destructive Behavior
26. Temper Tantrums
27. Hostile Behavior
28. Biting Others

Figure 5 MEASURES OF ANTI-SOCIAL BEHAVIOR

1. Number of Referrals to a Juvenile Department
2. Number of Referrals to a Juvenile Court
3. Number of Confinements in a Detention Home
4. Number of Jail Confinements
5. Number of Confinements in a Juvenile Reformatory
6. Number of Attempted Escapes from Criminal Justice Institutions
7. Number of Completed Escapes from Criminal Justice Institutions
8. Number of Appearances Before a Criminal Court as an Adult
9. Offenses Committed as a Juvenile
10. Offenses Committed as an Adult
11. History of Glue Sniffing
12. History of Alcohol Use
13. History of Drug Use

Figure 6 MEASURES OF DELINQUENCY

listing of the information gathered in this regard is outlined in Figure 7.

Basically, two procedures were utilized for gathering the information on the subjects. Some of the information used in this study is routinely gathered by the Department when an individual is first admitted to a state school. Some of this information is forwarded to the Department's central office in Austin and computerized for statistical analysis. Therefore, the Department was able to provide some of the information of concern to this study in machine readable form from their data processing center. The information thus provided mainly encompassed identification information including an IQ. Since the Department does not normally gather information about the prior criminal history of new admissions, this information had to be gathered from the subjects' caseworkers and individual case folders.

A machine readable data gathering instrument was developed and tested. A pilot study was initiated to determine the utility of the data gathering instrument so as to assure that the transfer of information from case folders would be expiditious. The data gathering instrument was subsequently modified and readied for implementation.

Using the computer tapes supplied by the Department of Mental Health and Mental Retardation the researchers were able to identify the school of residence of each subject in the sample.

1. Age
2. Ethnic Background
3. Sex
4. School Attendance Record
5. Marital Status
6. Marital Status of Parents
7. Family Work History
8. Family Income
9. IQ
10. Secondary Cranial Anomalies
11. Presence of Genetic Component
12. Presence of Genetic Component
13. Convulsive Disorder
14. Motor Dysfunction
15. Adaptive Behavior Level
16. Source of Admission Level
17. Type of Admission
18. Current Residential Status
19. Current Institutional Status
20. Number of Institutionalized Siblings

Figure 7 BACKGROUND INFORMATION

Research teams were sent to each of the schools to contact the caseworkers of the subjects in the sample. Each caseworker was informed as to the purpose of the study and was trained in the use of the data collection instrument. The caseworkers were requested to provide the information requested on the data gathering instrument utilizing both the subject's case history record as well as their own knowledge and familiarity with the subject. Since the manifestation of the anti-social behaviors outlined in Figure 2 would not be normally recorded in the subjects' case folders, the judgement as to whether the subject manifested these behaviors had to be made by the caseworkers. Unfortunately, no validity checks could be built into the questionnaire to determine the accuracy of the judgements of the caseworkers, particularly with regard to the child's manifestation of these anti-social and delinquent acts. However, the professional stature of the caseworkers within the school coupled with their familiarity with the behavior of the subjects provides some assurity as to the reliability of the judgemental data gathered.

Footnotes

[1]Vernon's Texas Civil Statutes, Article 2338, Sec. 3.

[2]Ibid.

[3]The variables listed in Figure 5 were derived from the Fairview Problem Behavior Record, developed by Robert T. Ross, Ph.D., Fairview State Hospital, Fairview, California, California State Printing Office, Sacramento, California, 1970.

4.0 RESULTS

This section contains the results of a variety of statistical analyses relating to the incidence of delinquency among residents of state schools for the retarded in Texas. For organizational purposes, this section is divided into five parts including; a resume of background information on the 430 individuals in the sample, diagnostic information on the nature of their retardation and physical disabilities, information as to the status of their current commitment, a summary of the incidence of various types of anti-social behavior, and, finally, information regarding the subjects' formal contacts with the criminal justice system.

To expedite statistical comparisons, the 430 subjects in the sample were divided into four groups, including males and females between the ages of 10 and 20, and males and females age 21 or over. Under Texas law, a juvenile is defined as any male age 10-17 and any female age 10-18. However, any juvenile who is formally adjudicated and committed to the Texas Youth Council can remain under the custody of the Council until his 21st birthday.[1] For this reason, the subjects were divided into age groups corresponding to the legal jurisdiction of the Texas Youth Council. All the tables presented in this section are organized so that comparisons can be made between juveniles and adults as well as males and females.

4.1 Background Information

The purpose of this section is to provide summary statistics describing the backgrounds of the 430 subjects in the sample. The sample included 240 (55.81%) males and 190 (44.19%) females. Defining juveniles as individuals of 20 years of age or less, the sample was composed of 362 juveniles (84.19%) and 64 adults (15.81%)

As indicated in Table 1, the majority of the subjects were Caucasian. However, the incidence of minority group members is somewhat different when comparing juveniles and adults. Approximately 1 in every 10 adults was Negro. It is interesting to note that the incidence of minority group members is higher among males than among females, regardless of age.

Table 2 provides limited statistical information on the history of school attendance among the subjects. Unfortunately, this data was not available on 29.7% of the sample. The incidence of missing data was particularly high for adults.

Table 3 records the marital status of the subjects in each of the four groups. Approximately 8 out of 10 of the subjects, regardless of group membership, were single. The incidence of divorce among the subjects is extremely low, however, this conclusion is tentative since the marital status of 48 of the subjects (11.16%) was not available.

Table 1

FREQUENCY DISTRIBUTION OF ETHNIC BACKGROUNDS

Ethnic Background	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Caucasian	120	58.82	102	64.55	17	75.00	27	84.37
Negro	56	27.45	42	26.58	4	11.11	3	9.37
Mexican-American	28	13.72	14	8.86	5	13.88	2	6.25
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 2

FREQUENCY DISTRIBUTION OF
SCHOOL ATTENDANCE RECORDS

School Attendance	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Unknown	51	25.00	44	27.84	15	41.66	18	56.25
Attended	109	53.43	89	56.32	4	11.11		
Did Not Attend	44	21.57	25	15.82	17	47.22	14	43.75
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 3

FREQUENCY DISTRIBUTION OF
PERSONS BY MARITAL STATUS

Marital Status	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Single	176	86.27	146	92.40	28	77.77	27	84.37
Married								
Divorced	1	0.49	1	0.63	1	2.77	1	3.12
Separated								
Annulled								
Widowed								
Deserted							1	3.12
Unknown	27	13.23	11	6.96	7	19.44	3	9.37
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Tables 4 through 6 summarize various characteristics of the family backgrounds of the subjects in the sample. Approximately 4 out of 10 of the juveniles' parents were married and living together. The incidence of divorce in the families of the juveniles is somewhat higher for females (25.31%) than for males (17.64%). The incidence of divorce in the families of the adult subjects is less than that among juveniles. However, as might be expected, the incidence of a deceased father and/or a deceased mother is substantially higher among the adult subjects.

Approximately one-third of the juvenile subjects came from families where the father was the principle economic provider as indicated in Table 5. In the case of the adult subjects, it is difficult to generalize as to the work history of their families since no information was available on 32 subjects (47%).

Table 6 presents a frequency distribution of the family incomes of the subjects in all four groups. Unfortunately, this information was not available on the majority of the subjects and makes interpretation of family income data quite tentative. However, considering those subjects on whom family income data was available, it would appear that the majority of the subjects came from the lower socio-economic level and were subsiding on incomes of less than $100 a week.

Table 4

FREQUENCY DISTRIBUTION OF
MARITAL STATUS OF PARENTS

Marital Status of Parents	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Unmarried	4	1.96	12	7.59			2	6.25
Married, Living Together	93	45.58	66	41.77	8	22.22	8	25.00
Married, Living Apart	4	1.96	3	1.89				
Divorced, Separated, Deserted	36	17.64	40	25.31	4	11.11	5	15.62
Father Deceased	22	10.78	7	4.43	6	16.66	5	15.62
Mother Deceased	4	1.96	5	3.16	3	8.33		
Both Deceased	2	0.98	2	1.26	8	22.22	7	21.87
Unknown	39	19.11	23	14.56	7	19.44	5	15.62
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 5

FREQUENCY DISTRIBUTION OF
WORK HISTORY OF FAMILY

Work History	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Male Head Works	71	34.80	56	35.44	3	8.33	7	21.87
Female Head Works	20	9.80	14	8.86	4	11.11	3	9.37
Both Work	27	13.23	23	14.55	4	11.11	3	9.37
Neither Work	4	1.96	6	3.79	3	8.33	1	3.12
Male Head Does Not Work								
Female Head Does Not Work	23	11.27	15	9.49	3	8.33	5	15.62
Unknown	59	28.91	44	27.85	19	52.78	13	40.62
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 6

FREQUENCY DISTRIBUTION OF
WEEKLY INCOME OF FAMILY

Income Per Week	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
$ 50/less	10	4.90	4	2.53	1	2.77	1	3.12
50-100	25	12.25	15	9.49	2	5.55	1	3.12
100-200	25	12.25	20	12.65	2	5.55	7	21.87
Over $200	11	5.39	14	8.86	1	2.77	2	6.25
Welfare/Assistance	16	7.84	16	10.12	3	8.33	4	12.50
Unknown	117	56.34	89	56.33	27	75.00	17	53.12
Totals	204	100.00	158	100.00	36	100.00	32	100.00

4.2 Diagnostic Information

This section contains statistical tables describing the nature of the subjects retardation and various attendant physiological disorders. Table 7 provides a frequency distribution of Wechsler Adult Intelligence Test scores for the four groups. Examination of the median and mean IQs indicates that the average intelligence level for adults is somewhat higher than that of juveniles. However, there does not appear to be any difference in average intelligence level when comparing juvenile males and females. It will be noticed that no IQs are reported below 35. This is because only subjects with IQs of 35 or greater were selected into the sample.

Tables 8 through 13 provide information on the frequency of genetic and physiological impairment associated with the subjects. This information was obtained from the data processing services of the Department of Mental Health and Mental Retardation. Of those who were examined for genetic disorders, 360 were found to have no such disorder. Of the remainder, the most common diagnosis was a genetic disorder of an undetermined sort. The presence of other genetic disorders, such as multiple gene type transmission, sex-linked recessive characteristics, single dominant gene transmission, and single recessive gene transmission, were negligible.

Table 9 indicates that the frequency of secondary cranial anomalies is negligible. This is most likely the result of the fact that only subjects with IQs of 35 or greater and

Table 7

FREQUENCY DISTRIBUTION OF WAIS IQ SCORES

IQ Score	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
30-39	19	9.31	12	7.59	1	2.78	3	9.38
40-49	62	30.39	47	29.75	11	30.56	7	21.88
50-59	60	29.41	48	30.38	7	19.44	10	31.25
60-69	31	15.20	33	20.89	9	5.70	7	21.88
70-79	24	11.76	15	9.49	7	4.43	3	9.38
80-89	8	3.92	3	1.90	1	2.78	2	6.25
Totals	204	100.00	158	100.00	36	100.00	32	100.00
Mean	54.50		54.48		57.53		56.19	
Median	53.00		53.67		58.00		55.50	
Standard Deviation	12.43		11.35		14.50		12.06	

Table 8

FREQUENCY DISTRIBUTION OF
PRESENCE OF GENETIC COMPONENT

Genetic Component	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
No Apparent Genetic Mechanism Present	171	83.82	130	82.27	32	88.88	27	84.37
Undetermined Genetic Mechanism Present	30	14.70	27	17.08	4	11.11	4	12.50
Multiple Gene Type Transmission	3	1.47					1	3.12
Sex Linked Recessive Gene Transmission								
Single Dominant Gene Type Transmission			1	0.63				
Single Recessive Gene Type Transmission								
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 9

FREQUENCY DISTRIBUTION OF PERSONS
BY PRESENCE OF SECONDARY CRANIAL ANOMALY

Cranial Anomaly	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
No Secondary Cranial Anomaly Present	143	70.09	98	62.02	25	69.44	11	34.37
With Secondary Cranial Anomaly But Not Further Specified	55	26.96	55	34.81	11	30.55	21	65.62
Hydrocephalus Secondary								
Microcephaly Secondary	5	2.45	4	2.53				
Other	1	0.49	1	0.63				
Totals	204	100.00	158	100.00	36	100.00	32	100.00

those not suffering from severe physical handicaps were included in the sample.

An attempt was made to determine the incidence of subjects who had sensory impairments. As indicated in Table 10, the incidence of such impairments is very low, most probably stemming from the fact that individuals with significant physical handicaps were excluded from this sample.

An attempt was also made to determine the incidence of various types of convulsive disorders in the sample. As indicated in Table 11, the incidence of such disorders is low, although it is somewhat higher in the male members of the sample than the females. Of the seizures identified, the most common were classified as major motor seizures. The incidence of other types of seizures such as petit mal, psychomotor seizures, akinetic, autonomic, and facial seizures was negligible or non-existent.

Some subjects were found to display various types of motor dysfunctions, as indicated in Table 12. Approximately 1 in every 10 subjects were found to have manifest various types of motor dysfunctions. In comparing males and females and juveniles and adults, no difference in the incidence of such dysfunction is apparent.

The Department of Mental Health and Mental Retardation attempts to classify institutionalized retardates in terms of adaptive

Table 10

FREQUENCY DISTRIBUTION OF
IMPAIRMENT OF SPECIAL SENSES

Impairment	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
No Sensory Impairment	179	87.74	147	93.03	33	91.66	30	93.75
Blind								
Deaf	4	1.96						
Hearing Handicapped	5	2.45	2	1.26	1	2.77		
Visually Handicapped	14	6.86	6	3.79	2	5.55	2	6.25
Deaf-Blind								
Blind and Hearing Handicapped								
Deaf and Visual Handicapped								
Hearing and Visual Handicapped								
Other	1	0.49						
Impairment; Not Specified	1	0.49	3	1.89				
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 11

FREQUENCY DISTRIBUTION OF CONVULSIVE DISORDER

Convulsive Disorder	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
No Convulsive Disorder Present	171	83.82	140	88.60	29	80.55	32	100.00
Akinetic Seizures								
Autonomic Seizures								
Focal Seizures								
Major Motor Seizures	15	7.35	8	5.06	5	13.88		
Mixed Unclassified Seizures	1	0.49	5	3.16				
Myoclonic Seizures								
Petit Mal Seizures	3	1.47	1	0.63				
Psychomotor Seizures	3	1.47	1	0.63				
Other								
Convulsive Disorder Not Further Specified	11	5.39	3	1.89	2	5.55		
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 12

FREQUENCY DISTRIBUTION OF MOTOR DYSFUNCTION

Motor Dysfunction	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
No Motor Dysfunction	183	89.70	145	91.77	33	91.66	29	90.62
Ataxia	1	0.49	2	1.26				
Atonia	3	1.47	2	1.26				
Athetosis	1	0.49						
Chorea								
Dystonia	1	0.49	1	0.63				
Rigidity					1	2.77		
Tremors								
Spasticity	1	0.49	3	1.89	1	2.77		
Mixed	1	0.49	1	0.63			1	3.12
Motor Dysfunction Not Further Specified	13	6.37	4	2.53	1	2.77	2	6.25
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 13

FREQUENCY DISTRIBUTION OF ADAPTIVE BEHAVIOR LEVEL

Behavior Level	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Unknown	71	34.80	64	40.50	14	38.88	20	62.50
Mild-Level I	48	23.52	32	20.25	9	25.00	3	9.37
Moderate-Level II	56	27.45	43	27.21	9	25.00	5	15.62
Severe-Level III	25	12.25	18	11.39	3	8.33	4	12.50
Profound-Level IV	2	0.98	1	0.63				
No Retardation	2	0.98			1	2.77		
Totals	204	100.00	158	100.00	36	100.00	32	100.00

bahavior level. It is somewhat difficult to compare the four groups with respect to adaptive behavior level since there is a disparity in the percentage of subjects for whom no information was available, particularly in the case of adult females.

4.3 Current Commitment Information

Tables 14 through 18 summarize various aspects of the subjects' current commitments. As indicated in Table 14, the predominant source of commitment referral was the family or relative of the retarded individual, which accounts for better than one-half of the commitments, regardless of group membership. The next most common source of referral for all groups were social workers, usually involved with a community agency. Although differences in source of referral appear when comparing juveniles with adults and males with females, no patterns are evident which lend themselves to ready explanation.

As indicated in Table 15, approximately one-half of the subjects were first admissions to the Department. However, it is interesting to note that the incidence of prior commitments in a state mental hospital is substantially higher among adults than among juveniles. This admission classification accounts for 30.55% of adult males and 15.62% of adult females. Similarly, the readmission of subjects who had previously been residents of one of the state schools is substantially higher among adult males (22.22%) and adult females (31.25%) than among juveniles.

Table 14

FREQUENCY DISTRIBUTION OF
SOURCE OF REFERRAL FOR ADMISSION

Source of Referral	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
State Board Operated Institution	26	12.74	2	1.26	6	16.66	3	9.37
Private Special Hospital	8	3.92	10	6.32				
State Clinic Operated by Board			1	0.63			1	3.12
State Operated Clinic	1	0.49	1	0.63	1	2.77		
Private Physician	2	0.98	5	3.16			4	12.50
Minister	1	0.49						
Social Worker	40	19.60	35	22.15	1	2.77	5	15.62
Health Officer	2	0.98	1	0.63	1	2.77		
Judge, Lawyer Legal	17	8.33	7	4.43	2	5.55		
Relative	103	50.49	92	58.22	24	66.66	18	56.25
Friend	2	0.98	3	1.89	1	2.77	1	3.12
Self	1	0.49						
Unknown	1	0.49	1	0.63				
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 15

FREQUENCY DISTRIBUTION OF TYPE OF ADMISSION

Type of Admission	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
First Admission	120	58.82	106	67.08	17	47.22	17	53.12
Readmission: Previous TDMHMR Facility for MR	28	13.72	20	12.65	8	22.22	10	31.25
Transfer from State School for MR	28	13.72	18	11.39				
Readmission: First to TDMHMR	8	3.92	8	5.06				
Readmission: First to MR Previous Patient TSMH	17	8.33	6	3.79	11	30.55	5	15.62
Return From Medical Furlough From TSMH	1	0.49						
Return From Medical Furlough Non-TDMHMR Facility	2	0.98						
Totals	204	100.00	158	100.00	36	100.00	32	100.00

TDMHMR - Texas Department of Mental Health and Mental Retardation
TSMH - Texas State Mental Hospital
MR - Mental Retardation

As mentioned previously, the subjects used in the study represented all admissions to the state schools for the retarded during fiscal year 1970 who were 10 years old or greater, had IQs of 35 or greater, and were not severely physically handicapped. Table 16 presents information as to the residential status of the subjects at the time the study was implemented. As the data indicates, more than one-half of the subjects were still residents of a state school at the time the data was gathered. Considering all groups combined, 71 of the subjects (16.51%) had been terminated and discharged from the Department. Similarly, 26 of the subjects (6.04%), considered active cases, eloped or were home on furlough, while 59 inactive cases (13.72%) had eloped or were on furlough.

Unfortunately, data on the institutional status of a number of the subjects was unavailable, as indicated in Table 17, making comparisons among the four groups somewhat tentative. However, it would appear that the incidence of subjects in the custodial group is substantially higher for males, regardless of their age, than for females. The data also indicate that the incidence of individuals considered potentially good risks for returning to the community is almost twice as high for juveniles than for adults, regardless of sex.

An attempt was made to determine the number of subjects who had institutionalized retarded siblings. As indicated in Table 18, the incidence is highest for adult females (9.37%)

Table 16

FREQUENCY DISTRIBUTION OF CURRENT RESIDENTIAL STATUS

Residential Status	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Resident	122	59.80	108	68.35	23	63.88	21	65.62
Furlough/ Elopement	12	5.88	11	6.96	1	2.77	2	6.25
Termination	38	18.62	18	11.39	8	22.22	7	21.87
Inactive Furlough/ Elopement	32	15.68	21	13.29	4	11.11	2	6.25
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 17

FREQUENCY DISTRIBUTION OF INSTITUTIONAL STATUS

Institutional Status	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Unknown	72	35.29	74	46.83	14	38.88	22	68.75
Custodial Group	47	23.03	18	11.39	15	41.66	4	12.50
Part Time Helper Group	23	11.27	20	12.65	4	11.11	2	6.25
Full Time Helper Group	18	8.82	15	9.49			1	3.12
Potential Community Returnee	44	21.56	31	19.62	3	8.33	3	9.37
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 18

FREQUENCY DISTRIBUTION OF SUBJECTS
WITH INSTITUTIONALIZED SIBLINGS

Number of Siblings	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Has Institutionalized Siblings	18	8.82	13	8.22	1	2.77	3	9.37
Does Not Have Institutionalized Siblings	186	91.17	145	91.77	35	97.22	29	90.62
Totals	204	100.00	158	100.00	36	100.00	32	100.00

and lowest for adult males (2.77%). The data on the number of institutionalized siblings for juvenile subjects indicates that the incidence is between 8% and 9% with virtually no difference when comparing males and females.

4.4 Incidence of Anti-Social Behavior

The primary purpose of this study was to identify the incidence of anti-social behavior among residents of state schools for the mentally retarded. If the term delinquency was confined to arrests and formal contacts with the criminal justice process, the results of the study would be extremely limited. This stems from the fact that while an individual is within a state school, even though he may commit acts which would be delinquent for a juvenile, if not criminal for an adult, it would be rare for him to be prosecuted for such acts. Therefore, an attempt was made to identify a variety of behaviors which could be considered anti-social or predelinquent in nature. These behaviors include acts for which a juvenile could be adjudicated under the State's definition of incorrigibility or for which an adult could be prosecuted.[2]

Table 19 provides a statistical summary of the incidence of each of the anti-social behaviors investigated. The data in the Table represent the number of subjects in each group who were found to manifest each behavior.

The most common anti-social behavior among all subjects was temper tantrums. It is the predominant acting-out behavior

Table 19

FREQUENCY DISTRIBUTION OF ANTI-SOCIAL BEHAVIOR

Behavior	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Ingestion - Inedible Substances	1	0.49	2	1.26				
Putting Objects in Nose/Ear	1	0.49	1	0.63				
Enuresis	9	4.41	5	3.16	1	2.77	1	3.12
Regurgitory Behavior	1	0.49	1	0.63				
Undressing Publicly	3	1.47	2	1.26			1	3.12
Unresponsive/Withdrawal	22	10.78	17	10.75	2	5.55	4	12.50
Smearing Feces	1	0.49			1	2.77		
Running Away	21	10.29	19	12.02	1	2.77	1	3.12
Lying	66	32.35	42	26.58	7	19.44	3	9.37
Destroying Own Clothing	12	5.85	10	6.32	1	2.77	1	3.12
Sexually Aggressive	27	13.23	29	18.35	3	8.33	4	12.50
Stealing	47	23.03	23	14.55	3	8.33	1	3.12
Homosexual Acts	26	12.48	8	5.06	2	5.55		
Heterosexual Acts	41	20.09	47	29.74	7	19.44	3	9.37
Noisy Behavior	34	16.66	31	19.62	3	8.33	3	9.37
Masturbation	60	29.41	9	5.69	8	22.22	1	3.12
Head Banging	2	0.98	4	2.53	1	2.77		
Biting Self	99	4.41	4	2.53			1	3.12

Table 19 (continued)

FREQUENCY DISTRIBUTION OF ANTI-SOCIAL BEHAVIOR

Behavior	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Hyperactive	41	20.09	29	18.35	3	8.33	8	25.00
Screaming	25	12.25	21	13.29	2	5.55	1	3.12
Assault-Employees	19	9.31	19	12.02	2	5.55	1	3.12
Assault-Patients	49	24.01	24	15.18	2	5.55	3	9.37
Breaking Windows	21	10.29	11	6.96				
Destroying Property	27	13.23	15	9.49	2	5.55		
Destructive Behavior	20	9.80	12	7.59	4	11.11	1	3.12
Temper Tantrums	74	36.27	39	24.68	9	25.00	10	31.25
Hostile Behavior	57	27.94	35	22.15	5	13.88	5	15.62
Biting Others	19	9.31	5	3.16			1	3.12

among juvenile and adult males and for adult females. It ranks third among the various anti-social behaviors for juvenile females. The second most common anti-social behavior for juveniles is lying, which is a characteristic also typical of 19.44% of the adult males. Lying was not commonly found among adult females.

As might be expected, masturbation was a more commonly reported anti-social behavior among the males than the females. It ranked third in the types of anti-social behavior among juvenile males and second among adult males.

The manifestation of hostile behavior or hostile attitudes ranked fourth among anti-social behaviors among juveniles, regardless of sex. Although the incidence of this behavior was somewhat less among adults, it is a fairly common behavior and characterized the behavior of 13.88% of the males and 15.62% of the females. Assaultive behavior, particularly directed toward other patients, is characteristic of juvenile males (24.01%) and to a lesser extent juvenile females (15.18%). However, assault of other patients is relatively uncharacteristic of adults, regardless of sex.

Stealing appears to be a relatively frequent problem among juvenile males (23.03%) and, to a lesser extent, among juvenile females (14.55%). However, it is not found too frequently among adults, regardless of sex.

The data also indicate that the incidence of heterosexual behavior is more common among juvenile females (29.74%) and adult males (19.44%) than it is among juvenile males or adult females. However, sexual aggressiveness of an assaultive nature, while relatively infrequent in occurance, is more typical of adult females than any other group.

In summarizing the data presented in Table 19, it would appear as though temper tantrums and generalized hostile behavior are the most common anti-social behaviors among institutionalized retardates, regardless of age and sex. Lying is also a characteristic that appears to generalize across groups with the exception of female adults. Comparison of the groups with respect to other anti-social behavior not mentioned above indicates that their frequency is minimal and there does not appear to be any substantial differences among the groups.

4.5 Delinquency History

The primary objective of this study was to determine the incidence of delinquent behavior among residents of state schools for the retarded. This section presents statistical information gathered on the incidence of arrests and adjudications involving the subjects in the sample.

Table 20 records the number of times the subjects had been referred to juvenile authorities prior to their residency in a state school. As indicated in the table, the incidence of such referrals is relatively low, although such referrals

Table 20

FREQUENCY DISTRIBUTION OF
REFERRALS TO JUVENILE AUTHORITIES

Number of Referrals	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	190	93.13	155	98.01	36	100.00	31	96.87
1	4	1.96	2	1.26				
2	3	1.47	1	0.63				
3	5	2.45						
4	1	0.49						
5	1	0.49					1	3.12
Totals	204	100.00	158	100.00	36	100.00	32	100.00

tend to be more characteristic of juveniles than adults. Similarly, the incidence of individuals who had been referred to the juvenile court for formal adjudication is extremely low, though more common among juvenile males than among any other group, as indicated in Table 21.

Under Texas law, once a juvenile has been arrested he must be remanded to the custody of his parents as soon as possible. If the parents are unavailable, or it would endanger the juvenile to be returned to his parents, the court may confine him to a detention facility for as long as necessary.[3] Table 22 records the incidence of such detentions among the subjects in the sample. The data indicates that the incidence of detention confinements is negligible although more common among juvenile males than any other group in the study. Similarly, the incidence of jail confinements as a juvenile is negligible, although more common among juveniles than adults, as indicated in Table 23.

In Texas, a juvenile who has been adjudicated and declared a delinquent may be committed to one of the state training schools administered by the Texas Youth Council.[4] Table 24 records the incidence of such confinements and indicates that the incidence is very low. Of those who had been so committed, the incidence is higher among juvenile males than any other group in the study.

Table 21

FREQUENCY DISTRIBUTION OF
REFERRALS TO COURT AS A JUVENILE

Number of Referrals	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	197	96.56	157	99.36	35	97.22	32	100.00
1	3	1.47	1	0.63	1	2.77		
2	2	0.98						
3	1	0.49						
4	1	0.49						
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 22

FREQUENCY DISTRIBUTION OF
CONFINEMENTS IN DETENTION HOMES

Number of Confinements	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	199	97.54	156	98.73	36	100.00	32	100.00
1	1	0.49	2	1.26				
2	2	0.98						
3	2	0.98						
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 23

FREQUENCY DISTRIBUTION OF JAIL CONFINEMENTS

Number of Confinements	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	198	97.05	156	98.73	36	100.00	32	100.00
1	2	0.98	2	1.26				
2								
3	4	1.96						
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 24

FREQUENCY DISTRIBUTION OF
CONFINEMENTS IN TRAINING SCHOOLS/TYC

Number of Confinements	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	197	96.56	155	98.10	36	100.00	32	100.00
1	2	0.98	2	1.26				
2	3	1.47						
3	2	0.98	1	0.63				
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Tables 25 and 26 present information on the number of attempted and completed escapes by the subjects when they were residents of a juvenile confinement facility. The data indicates that the incidence of such escapes is very low steming from the fact that not many of the subjects in the sample had ever been confined in a juvenile institution. As might be expected from the data discussed above, the incidence of escapes and attempted escapes exclusively involve juvenile males.

Table 27 records the number of subjects who appeared before a criminal court as an adult. By definition, the juvenile subjects in the sample could not have been before an adult criminal court unless certified as an adult. Among the adults, only three were found to have made such appearance, all being adult males.

An attempt was made to characterize the nature of the delinquent and criminal acts committed by the subjects, when juveniles, prior to their being admitted to a state school for the retarded. Table 28 indicates the number of individuals who had committed various types of delinquent offenses. Although the incidence of the commission of such offenses is very low among those subjects about whom such information was available, the most common type of delinquent act was running away, followed by burglary, involvement with stolen property and malicious mischief. As indicated in the Table, the commission of these types of delinquent offenses is predominantly characteristic of juveniles; particularly juvenile males. The incidence of

Table 25

FREQUENCY DISTRIBUTION OF
ESCAPE ATTEMPTS AS A JUVENILE

Number of Attempts	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	200	98.03	158	100.00	36	100.00	32	100.00
2	2	0.98						
4	1	0.49						
12	1	0.49						
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 26

FREQUENCY DISTRIBUTION OF
COMPLETED ESCAPES AS A JUVENILE

Number of Escapes	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	201	98.52	158	100.00	36	100.00	32	100.00
1	1	0.49						
2	1	0.49						
3	1	0.49						
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 27

FREQUENCY DISTRIBUTION OF APPEARANCES
BEFORE A CRIMINAL COURT AS AN ADULT

Number of Referrals	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
0	204	100.00	158	100.00	33	91.66	32	100.00
1					3	8.33		
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 28

FREQUENCY DISTRIBUTION OF OFFENSES
COMMITTED AS A JUVENILE

Offense	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Murder							1	3.12
Rape	1	0.49						
Assault	1	0.49	1	0.63				
Burglary	3	1.47						
Theft over $50	2	0.98						
Auto Theft	2	0.98						
Other Theft	2	0.98						
Forgery								
Fraud								
Stolen Property	3	1.47	1	0.63				
Weapons								
Prostitution	1	0.49						
Sex Offenses			2	1.26				
Drugs								
Gambling								
Arson	2	0.98						
DWI								
Liquor								
B&E M V	1	0.49						
Embezzlement								
Carelessness, Malicious Mischief	3	1.47	1	0.63				
Conspiracy	1	0.49						
Robbery	1	0.49						
School Truancy	2	0.98	1	0.63				

Table 28 (continued)

FREQUENCY DISTRIBUTION OF OFFENSES
COMMITTED AS A JUVENILE

Offense	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Run Away	6	2.94	3	1.89				
Ungovernable	2	0.98	2	1.26				
Vagrancy								
Homocide or Attempt								
Injury to Person(s)								
Glue Sniffing								
Traffic Violoations								
Other			2	1.26				

prior delinquent behavior is negligible when considering adult males and females.

The data gathered concerning crimes committed as adults indicates that only one adult in the sample was known to have committed a felonious crime. The crime committed involved a sexual offense and was perpetrated by an adult male.

Tables 29 through 31 provide information on the subjects' use of drugs and alcohol prior to being admitted to a state school. The data indicate that very few of the subjects had a prior history of either glue sniffing, alcohol abuse, or the use of drugs. Of the few individuals involved with these substances, all were juveniles.

In summarizing this section on the delinquency histories of the subjects it is evident that very few of the subjects had any prior contact with the juvenile or adult criminal justice system. Those who had such contacts were predominantly males and most of their contacts were as juveniles, not as adults.

Footnotes

[1]Vernon's Texas Civil Statutes, Article 5143d, Sec. 9a.

[2]Vernon's Texas Civil Statutes, Article 2338, Sec. 3f.

[3]Vernon's Texas Penal Code, Article 113, Sec. 11 and Sec. 17.

[4]Vernon's Texas Civil Statutes, Article 5143d, Sec. 1.

[5]Vernon's Texas Civil Statutes, Article 2338-1, Sec. 6.

Table 29

FREQUENCY DISTRIBUTION OF PERSONS
BY HISTORY OF GLUE SNIFFING

History of Glue Sniffing	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Yes	1	0.49	1	0.63				
No	203	99.50	157	99.36	36	100.00	32	100.00
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 30

FREQUENCY DISTRIBUTION OF PERSONS
BY HISTORY OF USE OF ALCOHOL

History of Alcohol Use	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Yes	3	1.47	1	0.63	1	2.77		
No	201	98.52	157	99.36	35	97.22	32	100.00
Totals	204	100.00	158	100.00	36	100.00	32	100.00

Table 31

FREQUENCY DISTRIBUTION OF PERSONS
BY HISTORY OF USE OF DRUGS

History of Drug Use	Juveniles				Adults			
	Males		Females		Males		Females	
	f	%	f	%	f	%	f	%
Yes			1	0.63				
No	204	100.00	157	99.36	36	100.00	32	100.00
Totals	204	100.00	158	100.00	36	100.00	32	100.00

5.0 SUMMARY AND CONCLUSIONS

The purpose of this study was to determine the extent of anti-social behavior and delinquency among new admissions to the state's residential facilities for the mentally retarded. The primary strategy in this study involved the identification of all new admissions to the Department of Mental Health and Mental Retardation during fiscal year 1970 who, if they had remained in the community, could possibly have been arrested and processed in the criminal justice system for delinquent or criminal behavior.

Many of the individuals admitted to the state's residential facilities for the mentally retarded would not, by the very nature of their disability and attendant physical handicaps be processed through the criminal justice system. It was theorized that individuals who were nonambulatory with IQs below 35 and with profound sensory and physical disabilities would, even if apprehended in the commission of a criminal act, be identified as mentally retarded and diverted from the criminal justice system. Similarly, mentally retarded individuals below the age of 10 could not, by law, be processed in the criminal justice system.

All new admissions to the Department during 1970 were screened using the aforementioned criteria resulting in a sample of 430 subjects including 362 juveniles and 68 adults.

Two procedures were developed to define anti-social behavior and delinquency among subjects in the sample. The first procedure involved determining whether the subjects had been formally processed either in the juvenile or adult criminal justice system prior to admission to a state residential facility. This included gathering information on such variables as number of arrests, nature of prior offenses, number of adjudications, dispositions, and etc.

Since mentally retarded individuals may commit delinquent or criminal acts while in a state residential facility, yet not be prosecuted for such behavior, another procedure was developed to identify the incidence of anti-social or delinquent acts while in residence at a state facility. This included identification of behaviors which, though not criminal if committed by an adult, could be construed as manifestations of anti-social behavior constituting incorrigibility as defined in the Texas Juvenile Code. This included such behaviors as temper tantrums, lying, etc., which, though not criminal in nature, are disruptive to the normal routine of a residential facility and characterize the behavior of the defective delinquent in a residential population.

5.1 Incidence of Anti-Social Behavior

The degree of anti-social institutional behavior manifested by the subjects varies greatly as a function of the type of behavior analyzed. It is evident that there are differences in the types of anti-social behaviors manifested when comparing males with

females and juveniles with adults. The most common behavior demonstrated by the subjects, regardless of age or sex, was temper tantrums. This behavior was observed in at least 1 of every 4 of the individuals studied and most commonly manifested by juvenile males. Another common behavior was lying, which characterized the behavior of approximately one-third of the juvenile males and was frequently found among juvenile females and adult males. Other common anti-social behavior involved masturbation, particularly among males, and the manifestation of hostile acts or attitudes which seems to be more common among juveniles, regardless of sex.

Of particular interest to this study is assaultive behavior which characterized 1 of every 4 of the juvenile males studied and approximately 1 of every 7 of the juvenile females. While this characteristic seems to be quite prevalent among younger individuals, it is relatively uncharacteristic of adults, regardless of sex. It was interesting to note in this regard that assaultiveness was primarily directed at other residents, althoug in some cases, the assaultive behavior was directed toward staff members. Other common anti-social behaviors involved theft, hetersexual acting-out, and sexual aggressiveness of an assaultiv nature.

In summarizing the incidence of anti-social institutional behavior, the data suggests that this is a significant problem among new admissions to state facilitities for the retarded. Although some of the anti-social behaviors are minor in nature,

others fall within the scope of criminal behavior as defined in either the Juvenile Code or the Penal Code of the state of Texas. Questions concerning the criminal culpability of these individuals notwithstanding, the manifestation of such behaviors is disruptive and can negatively affect the administration of state residential facilities. It must be realized that the state's residential facilities are not correctional institutions, nor is the staff of these institutions trained in security and custody procedures as would be the staff of a correctional facility. Certainly the fact that the residents have been diagnosed as mentally retarded reduces the degree of culpability for such behaviors within the administrative philosophy of state schools. Nonetheless, the problem of how best to deal with the anti-social retardate and whether to segregate him from other residents for his own protection or for the protection of others are difficult problems. The development of special facilities for the acting-out retardate is one solution to the problem. Yet, great care must be exercised in assuring that the civil liberties of these individuals are not violated by such segratory policies.

5.2 Delinquency History

The secondary aspect of this study involved investigation into the prior delinquency and criminal records accrued by the subjects prior to their admission to state residential facilities. The data gathered in this regard is somewhat unreliable since the Texas Department of Mental Health and Mental Retardation does not routinely conduct criminal history background

investigations on its residents. Therefore the data indicating the existence of such criminal activity prior to admission is, at best, a lower bound estimate of the true incidence.

The data on the subject's criminal histories indicates that no more than 10% had had any prior contact with the criminal justice system. While some, particularly male juveniles, had been referred to juvenile authorities prior to admittance, very few of the subjects had been processed through either the juvenile or adult criminal justice system.

When comparing the incidence of institutional anti-social behavior and prior contacts with the justice system an interesting question arises. How is it possible for a substantial number of the subjects to manifest anti-social and delinquent behavior while within the facility and, yet, have negligible prior involvement with the criminal justice system? This discrepancy might be explained in several ways. First, it should be recalled that the majority of the subjects in the sample were between 10 and 21 years of age. Since no individual under the age of 10 years of age can be held accountable for his actions before the law, the majority of the subjects had not been of a legal age for any extended period of time. This diminishes the possibility of their becoming involved in the juvenile justice system.

A second way of explaining the disparity could be based on the assumption that once an individual becomes involved with the criminal justice process, the opportunity for his entering a

state residential facility for the retarded is diminished. In other studies conducted by the authors, it is quite clear that if a mentally retarded juvenile is referred to the juvenile court he is more likely to be committed to the Texas Youth Council than diverted to residential facilities for the mentally retarded. Similarly, moderately retarded adults arrested for criminal acts usually resolve their cases through plea negotiations, with the issue of legal insanity or incompetency not normally being raised. As a result, a significant number of mentally retarded adults are prosecuted as normal criminals, and only infrequently diverted to state facilities for the mentally retarded or criminally insane.

5.3 Conclusions

Several conclusions can be drawn from the data gathered in this study. The investigation into the incidence of anti-social institutional behavior strongly suggests that a significant number of new admissions do manifest behavior which is probably disruptive to normal administration and which constitutes security problems within state residential facilities. The surprisingly high incidence of such behaviors suggests that residential facilities need to develop specialized programs and residential constraints to care and treat the defective delinquent. The development of such procedures is problematic since residential facilities are not correctional institutions and there are legal ambiguities concerning the extent of control a residential facility could exert in the case of an acting-out mentally retarded individual. A second factor which compounds the problem is the fact that the staff associated with residential facilities is not normally

trained in security and correctional practices. Their backgrounds are primarily in the social sciences and the lack of such training could mitigate against their proper handling of such individuals.

The second conclusion that can be drawn from this study is that very few mentally retarded individuals who have had previous involvement in the criminal justice system are among individuals admitted to state schools for the retarded. Other studies conducted by the authors indicate that approximately 10% of adults committed to the Texas Department of Corrections and approximately 14% of juveniles committed to the Texas Youth Council are mentally retarded. These studies clearly indicate that the majority of retarded delinquents and mentally handicapped adult offenders are committed to state correctional institutions and not to state facilities for the mentally retarded.

Finally, it must be concluded that mentally retarded individuals with delinquent tendencies can be found both within the state's correctional institutions and within residential facilities for the retarded. However, the delinquent retardates found in each type of institution tend to differ from each other. Those found in correctional institutions tend to be more moderately retarded and have more extensive criminal histories. Those found in state residential facilities for the retarded tend to be more profoundly retarded and have had little prior involvement with the criminal justice system.

The problem as to which agencies could best handle different types of mentally retarded delinquents is a complex issue and requires an examination and re-evaluation of the criminal law and the administrative practices of criminal justice agencies and agencies concerned with the mentally retarded. Certainly, no mentally retarded individual who is not aware of the consequences of his actions and cannot discriminate between right and wrong should be placed in a correctional facility. By the same token, however, some moderately retarded offenders are criminally culpable under this definition and it is not legally or theoretically inconsistent to provide for their care and treatment within a correctional institution.

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PROJECT CAMIO

Correctional Administration and the Mentally Incompetent Offender

Volume 1 Strategies for the Care and Treatment of the Mentally Retarded Offender

Volume 2 Theories on Criminality and Mental Retardation

Volume 3 The Mentally Retarded and the Law

Volume 4 The Mentally Retarded in an Adult Correctional Institution

Volume 5 The Mentally Retarded in a Juvenile Correctional Institution

Volume 6 The Delinquent in a State Residential Facility for the Mentally Retarded

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Volume 8 A National Survey of the Diagnosis and Treatment of Mentally Retarded Offenders in Correctional Institutions